

Sign language interpretation in health care situations in Flanders

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1. Some background information

Belgium is a territorially based multilingual country where Dutch is spoken in the northern part, i.e., Flanders, French in the southern part, i.e. Wallonia, and German in a relatively small area close to the German border. Next to the official spoken languages two sign languages have been recognized: Vlaamse Gebarentaal (Flemish Sign Language or VGT) recognized by Flemish Parliament in April 2006 and la Langue des Signes de Belgique Francophone (French Belgian Sign Language or LSFB) recognized by the Parliament of the Francophone Community in October 2003. However, this paper will only focus on VGT and the Flemish deaf community in which there are approximately five to six thousand VGT-users (Loots et al. 2003).

Since the 1980s there have been two sign language interpreter training programmes, one in Ghent, one in Mechelen, both in adult education, and both are now part-time 4 year-programmes (Van Herreweghe & Van Nuffel, 2000). Since 2008-2009 a new Bachelor in Applied Linguistics (with VGT as one of the two foreign languages studied) to be followed by a Master in sign language interpretation has been set up at Lessius Hogeschool (Antwerp). However, no interpreters have graduated from that programme yet.

In 1994 the “Communicatie Assistentie Bureau” was established as a central sign interpreting agency and has been subsidised by the Flemish Government since, so it basically holds a monopoly. Its main tasks are the following:

- When deaf (and hearing) clients send in an application for an interpreter, the agency looks for (and finds) an interpreter.
- The agency takes care of all the paper work, i.e., both application files for deaf clients and financial paperwork for interpreters.
- The agency is also the point of contact for the Flemish government (Van Herreweghe & Vermeerbergen, 2006).

As for financial arrangements, deaf people who have been granted the necessary status after their application has been approved, are entitled to a number of “interpreting hours” paid by the Flemish Government) (Van Herreweghe & Vermeerbergen, 2006):

- 18 (or max. 36) interpreting hours per year in “private” situations (e.g., to go to the notary when buying a house, for a parent-teacher conference at the school of the children, etc., but also in personal health care situations);

- 10% of work time for work related matters;
 - a differing number of hours in education (with a maximum of 12 hours per schoolweek).
- The interpreter's travel costs need to be paid by the (deaf) client and (at the time of writing) interpreters get an average of €31.4 per hour started.

In 2008 there were 142 active interpreters in Flanders of whom most interpret only irregularly as can be seen in the Table 1 (De Witte, 2008).

Table 1. Hours interpreted in 2008 by number of interpreters

| Hours interpreted in 2008 | Number of interpreters |
|---------------------------|------------------------|
| Fewer than 64 | 67 |
| 64 to 160 | 28 |
| 160 to 319 | 20 |
| 319 to 478 | 10 |
| 478 to 637 | 8 |
| 637 to 797 | 6 |
| More than 797 | 3 |
| Total | 142 |

According to the Central interpreting agency (cf. <http://www.cabvlaanderen.be>), there has been a slight raise in the past few years in the number of hours interpreted in private situations as is demonstrated with the difference between 2006 and 2008 in Table 2. Of the hours interpreted in private settings less than 10% went to health care situations (although we may have to be careful with the numbers since not all clients and interpreters report on this accurately) (De Witte, 2006 & De Witte, 2008).

Table 2. Number of interpreted hours in private situations and in health care settings

| Year | Hours in private situations | Hours in health care settings | Percentage |
|------|-----------------------------|-------------------------------|------------|
| 2006 | 4919 | 436 | 8.86% |

| | | | |
|------|------|-----|-------|
| 2008 | 5913 | 562 | 9.50% |
|------|------|-----|-------|

This seems to be corroborated by the information given by the interpreters in the questionnaires (see further down) as can be seen in Table 3. Only four interpreters report to already have interpreted more than 50 times in medical settings.

Table 3. Number of interpreters interpreting in general and in medical settings

| General \ Medical | 1-2 x /month | 3-5 x /month | 6-10x /month | More than 10x /month | unknown | Total |
|----------------------------------|---------------------|---------------------|---------------------|---------------------------------|----------------|--------------|
| 1-2x | | | | 1 | | 1 |
| 3-5x | | 1 | | 5 | | 6 |
| 6-10x | 2 | | 1 | 2 | | 5 |
| 10-50x | | | 2 | 3 | | 5 |
| More than 50x | | 1 | | 2 | 1 | 4 |
| Total | 2 | 2 | 3 | 13 | 1 | 21 |

This is strikingly different from the United States where deaf citizens are granted a general right to interpreting services both under section 504 of the Rehabilitation Act of 1973 and under the Americans with Disabilities Act (ADA). The result is, as one agency reported, that the majority of requests for services they receive are for medical interpreting (RID Views, 1999, p.13; in Swabey & Taylor, 2006)). Indeed, more recently Swabey, Alvarado-Little, & Taylor (in Swabey & Taylor, 2006) estimate the rate of medical requests in the US at 30-50%.

2. Methodology and participants

In order to get a first idea about issues and dilemmas in health care interpretation in Flemish Sign Language a questionnaire was e-mailed in the spring of 2009 to 144 active VGT interpreters and 25 filled-in questionnaires were returned. Four of them indicated that they had no experience with

interpretation in health care situations, so the remainder of this paper will be based on information from 21 questionnaires. Of those 21 respondents 19 were female and 2 male (more or less reflecting the proportion of female and male sign language interpreters in Flanders). They belonged to the following age groups: 18 – 29 years old: 5; 30 – 39 years old: 7; 40 – 49 years old: 5; and 50 – 59 years old: 4. Sixteen of them had graduated from the Ghent programme and four from the Mechelen programme. Most of them were living in the western part of Flanders: in East Flanders: 8; in West Flanders: 7; in Antwerp: 3; in Limburg: 1; in Flemish Brabant: 1; and 1 unknown.

From Table 1 it can be deduced that in 2008 only 17 interpreters interpreted more than 10 hours per week and nearly all of them responded to the questionnaire. Consequently, most of the questionnaires were returned by the more active and more recently graduated interpreters as can be seen in Table 4 (2 respondents did not provide their graduation year).

Table 4. Date of graduation x frequency of interpreting

| Graduation \ Frequency of interpreting | Before '81 or no certificate | '81 – '89 | '90 – '94 | '95 – '99 | '00 – '04 | '05 – '09 | Total |
|---|---|------------------|------------------|------------------|------------------|------------------|--------------|
| 1-2 x /month | | | | | | 2 | 2 |
| 3 – 5 x /month | | | 1 | | | 1 | 2 |
| 6 – 10 x /month | 1 | | | | 1 | 1 | 3 |
| More than 10x /month | 1 | 1 | | 2 | 2 | 6 | 12 |
| Total | 2 | 1 | 1 | 2 | 3 | 10 | 19 |

Next to the questionnaires information was obtained via a focus group discussion of about 2.5 hours with four very active interpreters in July 2009. Each of these had more than average experience of interpreting in health care settings. Finally I conducted a 2 hour in-depth interview (in Flemish Sign Language) with one deaf female adult in July 2009, who had been hospitalised about a year before.

3. Issues and dilemmas

3.1. Legal and financial issues

Table 5 gives an overview of the types of situations in which all the interpreters together report to have interpreted since their graduation. Again these numbers may not be accurate (since they are based solely on the questionnaires) but they do give an indication of the fact that not many deaf clients hire interpreters for a consult with their general practitioner but mostly hire an interpreter in more complex situations (for a consult with a specialist doctor, at hospitalisation, during an operation, etc.).

Table 5. Number of interpreted encounters in different health care situations.

| Health care situation | Number of interpreted encounters |
|---------------------------------------|--|
| Specialist doctor | 261 |
| General practitioner | 96 |
| Hospitalisation | 78 |
| Psychologist / Psychiatrist | More than 21 (mainly due to one interpreter who claimed to have interpreted in this setting “on a regular basis for one client”) |
| Operation | 19 |
| Work-related medical examination | 6 |
| Information session on pregnancy etc. | 4 |
| Medical school examination | 1 |
| Euthanasia counselling | 1 |
| Other | 1 |

Since deaf clients are only entitled to 18 hours of interpreter services a year in private situations, many are very careful about when to ask an interpreter so as to make sure that they still have enough hours left at the end of the year for possible emergencies. This is probably the main reason why interpreter services are hired more for specialist doctors than for general practitioners. Most deaf people seem to only hire an interpreter when they have to go to a new doctor and do not visit their own general practitioner with a interpreter. The deaf interviewee stated that she has had a good relation with her general practitioner for more than 30 years now and that in the last few years they have started to communicate to each other by means of

the computer where the general practitioner would type in a question and she would type a reply, etc. so that she would never hire an interpreter in that situation. According to her, this is what deaf people generally do in Flanders. An additional reason why so few deaf people hire an interpreter when they need a consult with their general practitioner is because they are afraid that they may lose valuable interpreter time when they have to wait in the waiting room before seeing the doctor, even when they have made / can make an appointment because it is always possible that the doctor runs behind. This seems to be comparable to the situation in the Netherlands where very few deaf people make use of an interpreter for a consult with their general practitioner (Smeijers & Pfau, 2009).

3.2. Practical issues

In the questionnaires a number of practical issues were reported on, and this was corroborated in the focus group discussion and in the interview with the deaf person. Some of these practical issues can actually easily be solved, but some are more difficult to be dealt with.

Some interpreters complained about basic issues such as finding the client, e.g. at the hospital entrance, in the waiting room, etc. when they have never seen the client before. A very simple solution to this would be for the interpreter to wear an interpreter's badge, but apparently some interpreters object to this for reasons of privacy.

Some practical issues are related to visibility as interpreter and deaf client need to be able to see each other at all times for communication to take place. Interpreters reported on doctors or nurses explaining or asking something when a deaf person is inside a scanner, during an eye examination or during psycho-therapeutic relaxation techniques by means of closing the eyes, etc. A solution to all of these problematic communicational situations is to ask the doctor or nurse to explain everything before visual contact between deaf client and interpreter is broken. Since it is frequently the case that the interpreter is the only person present who may have had experience in such situations, it seems to be advisable for the interpreter to negotiate this (and not expect doctor, nurse or deaf client to come up with this solution). Something similar occurs when a doctor explains by means of pointing at photo's, scans, etc. The doctor needs to point at something in silence while the deaf person (and the interpreter) can watch and the doctor can only afterwards give the explanation. A related issue is when interpretation in an ambulance is required. The interpreter needs to sit in the back together with the deaf client, but this is normally not allowed and needs to be negotiated (by the deaf client or by the interpreter?).

A more crucial issue is related to not having enough time, as one interpreter wrote down (my own translation):

“Sometimes the doctors treat the deaf patients as a minor and/or a retarded person or in a patronizing and childlike manner. When the doctor has enough time and the interpreter gets the time for proper introductions, then there are hardly any problems, but frequently the specialists haven’t got enough time and everything has to be sorted out quickly and then things go wrong at different levels and there’s a bitter aftertaste... I have often wondered if it wouldn’t make sense for the deaf person to say that s/he is deaf when s/he makes an appointment and to say that there will be an interpreter. Maybe in such a way annoying situations could be avoided. Not all deaf people are assertive enough to stand up to a doctor and instead let the interpreter explain and answer everything and make the arrangements, which is a role I do not like.”

Obviously this is not just a problem of time, but is emblematic of the power relation between doctor and patient. This also sometimes arises in the positioning of doctor, deaf patient and interpreter. It is normally advised that the interpreter sits next to or close to the doctor so that the deaf client can easily see both doctor and interpreter more or less at the same time. However, some doctors do not allow the interpreter to sit next to him/her, which may be due to a perceived invasion of this power relation. The solution to this would be for the deaf person to explain why this is necessary for his/her ease of communication. If the deaf person doesn’t do this, the interpreter may need to do, but this has to be broached very carefully, as one interpreter reported: “I always play the role of stupid interpreter, of underdog”.

Furthermore, some practical issues are related to potentially embarrassing situations when interpreters witness intimate examinations (e.g. prostate, gynaecology, etc.), esp. when they are of the opposite sex (which is frequently the case since there are many more female than male sign language interpreters in Flanders). Obviously this needs to be talked about beforehand, since some deaf patients and interpreters prefer it if the interpreter is not present during such an examination. In such a case all the necessary information of what the doctor is going to do is given (and interpreted) beforehand so that the interpreter can leave the surgery during the examination. Other deaf patients prefer the interpreter to remain present during the examination, and the interpreter then tries not to look at the deaf client’s naked body but keeps eye contact as much as possible. Most interpreters feel it is very important to know about this beforehand so as not to be surprised on the spot. The deaf interviewee recounted that her husband once during a medical examination had to undress, and when he came out of the dressing cubicle, the (female) interpreter was so shocked to see him naked that she immediately ran out of the surgery leaving him behind with no interpreter. Since then he has always talked to the interpreter before any examinations had to take place.

Finally, some potentially dangerous situations were reported on, especially in radiology where it is important for the interpreter to also be protected (which is sometimes forgotten) or to be asked

whether she is pregnant (which is even more frequently forgotten). It mostly seems to be the interpreter who has to take responsibility here.

3.3. Relational issues

In the questionnaires a number of relational issues were touched upon. Most interpreters (17 out of 21) prefer to only interpret in medical settings for clients they do not know personally. All claim that a relationship of trust is important (but that is also the case in other settings) and most claim that interpreters need to show empathy with the deaf client. Some interpreters reported to prefer not to interpret for somebody they know (reasonably) well when bad news is expected. This was corroborated by the deaf interviewee who recounted that one of her deaf friends took her hearing sister (who is also a sign language interpreter) with her for a consult with an oncologist. The doctor told the deaf patient that she had a lethal form of cancer and that she would probably only have three months to live, but the sister/interpreter was so taken aback by this news, that she did not interpret this (and even did not tell her sister afterwards either, so that the deaf patient never knew how serious her illness was).

At the same time, according to the interpreters, some deaf clients prefer an interpreter they know well (and trust) (and they afterwards like to talk to the interpreter as a friend about the medical problem), but some deaf clients prefer an interpreter they do not know at all. According to the deaf interviewee this has become more and more so since the case just mentioned above (which has stirred up a lot of discussion in the Flemish deaf community).

Some interpreters reported on the fact that they sometimes seem to find themselves “in the middle” since there can be a perceived allegiance of the interpreter with the health care provider and with the deaf patient (both as seen by the deaf client). Since both interpreter and health care provider are hearing, this can be felt as threatening so that some deaf patients may seem to be wary of issues of control by both hearing interactants over the deaf patient. This can mainly be solved by positioning the interpreter next to the doctor so that the doctor nearly has to address the deaf patient directly rather than addressing the interpreter (who is sitting next to him/her), which sometimes occurs. At the same time there can be a perceived allegiance of the interpreter with the deaf client since both use Flemish Sign Language and this seems to generate a feeling of trust. Apparently it frequently happens that the deaf client after the consult asks the interpreter whether it would be wise to follow the prescribed treatment, whether the interpreter thinks it’s a good doctor, etc. Due to this perceived allegiance some deaf clients seem to bestow more trust on the interpreter than on the doctor they have just visited.

3.4. The interpreter’s role

In sign language interpreting training programmes it is firmly stressed that the interpreter should behave as an objective professional and obviously adhere to the code of ethics in which impartiality, confidentiality, etc. is stressed. However, even though interpreters may be educated in this way, that frequently clashes with how health care providers and deaf clients see the interpreter's role.

3.4.1. From the perspective of the health care provider

Interpreters frequently reported that they are regularly regarded as counsellors or helpers by health care providers. Some examples mentioned by interpreters in the questionnaires and the focus group discussion are:

- the doctor asks the interpreter for background information about deaf patient (his/her personal and/or medical history, which medication the deaf patient takes, etc.);
- the doctor asks the interpreter for advice (e.g. "The doctor asked me: "How would you explain that to the deaf-and-dumb person; do you think he is intelligent enough to understand?"");
- the doctor / the nurse expects the interpreter to accompany the deaf patient to the changing room and to help him/her to undress;
- the doctor asks the interpreter to make sure that the deaf patient takes his/her medication every day;
- in case of an emergency when there are no family or friends around, the interpreter is expected to register the deaf patient (both in the ER and the hospital), to help carry bags, to get medication at the hospital chemist's, etc.;
- the receptionist explains to the interpreter where toilet, waiting room, X-rays, etc. are and expects the interpreter to accompany the deaf person to the toilet, waiting room, X-rays, etc.;
- the doctor expects the interpreter to text (after the consult) results of a biopsy to the deaf patient;
- the doctor expects the interpreter to drive the patient home afterwards.

Health care providers also frequently seem to think that the interpreter has a (romantic/sexual) relationship with the deaf client. This is probably due to the closer physical contact between the interpreter and the deaf client (in order to attract attention it is necessary for the one to touch the other on the arm, etc.). This seems to be especially a problem when the same interpreter interprets for the same patient for various consults with the same doctor. Consequently health care providers frequently expect the interpreter to be there when the deaf person has to undress completely (see above).

Finally, interpreters are usually regarded as Deaf culture specialists by the health care providers. Nurses sometimes ask for certain signs so that they can address the patient directly or they

sometimes ask advice as to how to go about contacting, addressing, etc. deaf patients. A few interpreters also reported on the odd occasion when a doctor doesn't know how to explain the medical problem to his/her patient, and starts explaining it to the interpreter, expecting the interpreter to be able to explain everything in such a way that the patient does understand.

3.4.2. From the perspective of the deaf client

Most interpreters reported on the fact that certain (not all) deaf clients clearly regard the interpreter as counsellor or helper, and when the interpreter doesn't want to take on this role, s/he is considered to be a bad interpreter (whose services they won't use again). Many interpreters reported on being in a waiting room together with the deaf client when the deaf client starts explaining his/her medical history to the interpreter and asks the interpreter for advice. A good many deaf clients apparently expect the interpreter to explain his/her problem to the doctor, and this is especially the case when the same interpreter has interpreted for the patient before and/or when they had already talked about this in waiting room. Some interpreters therefore avoid being in the waiting room together with the deaf client.

One interpreter reported on an instance when she was portrayed as a Deaf culture specialist by the deaf client to the doctor: an otologist wanted to implant the deaf client's child with a cochlear implant, but the deaf person was strongly opposed to this intervention and sought help from the interpreter to explain to the specialist doctor why he did not want this.

3.4.3. From the perspective of the interpreter

Usually interpreters regard themselves as objective professionals (in line with their training), but sometimes interpreters feel they need to be cultural mediators and are not sure whether they are allowed to do this. One (recurrent) example is when a doctor asks the deaf patient how s/he feels and the deaf patient would explain their medical history starting ten years before (as is fairly customary in the Deaf world and as such this can be regarded as a cultural difference). Some interpreters feel they need to explain to the doctor that this is "the Deaf way" rather than just interpreting all of this. Other interpreters feel they need to explain to the deaf client that the doctor only wants more recent information.

However, a few interpreters acted differently. Some examples from the questionnaires:

- "Especially in medical situations I would ask for extra information when you know that it is important but when the deaf client doesn't think about it at the time".
- "When the doctor starts talking about medication I'll immediately ask him/her to write that down even when the deaf client doesn't ask it him-/herself, or when the doctor refers to another doctor I'll ask the doctor to legibly write down the necessary information".

- “The doctor writes down in short how much medication the patient needs and asks me to explain it to her in detail. I afterwards made a complete scheme on how and when to take medication as I thought it too important”.
- “If a next appointment needs to be made, I’ll ask the receptionist to already take care of that so that I can be there as well (obviously only with consent of the deaf client)”.
- “Sometimes you need to encourage the deaf person to ask questions; sometimes you repeat this when you see that the deaf person is afraid and doesn’t dare to ask questions. You sometimes need to interpret this towards the doctor (if you interpret regularly for the same client you can see from their body language when they dare to be assertive and when they don’t)”.

These examples were presented in the focus group discussion and were strongly rejected by the interpreters present as unprofessional behaviour, but all of them acknowledged the fact that these examples are not all that exceptional and that they all know interpreters who would act in such a way.

3.5. Ethical issues and dilemmas

Finally all interpreters mentioned the fact that had experienced struggles with certain ethical issues and dilemmas and that they did not always know how to deal with these. Some examples mentioned are:

- The doctor asks the interpreter not to interpret something. This can be a negative remark with respect to the deaf client as: “It’s always the same with these deaf people, they always want more points on their disability scale”. Or it can even be worse: “Once the doctor was telling me how stupid the deaf client was and I interpreted that of course, so that the doctor was angry, and naturally the deaf person as well”. Fairly frequently this relates to a conversation with another doctor, or members of the family, etc. It seems that many health care providers only expect the interpreter to interpret what is being said between doctor and patient, but no conversations with other people present. Some doctors can actually get quite angry when they realise the interpreter is also interpreting these other conversations.
- On the opposite side it also happens that when a deaf client is accompanied by their deaf partner and the interpreter interprets private conversations between the two, that this is considered problematical by the deaf client. One interpreter reported on a deaf client getting really angry with her because she had interpreted the conversation between the deaf client and their deaf partner about how to get the most out of a work-related medical exam.
- In hospital, other patients sharing the same room with the deaf patient frequently ask the interpreter to explain what is wrong with the deaf patient or tell the interpreter (impertinent) things about the patient when the patient has left the room. Therefore

most interpreters feel it is better to also leave the room when the deaf person has to go (for whatever reason).

- Some interpreters stated that a doctor had suggested that in future it would be better to have a hearing family member instead of an interpreter, so that he can explain everything to the hearing family member instead which goes a lot faster according to the doctor.
- When the patient is treated in a patronizing way, interpreters frequently feel the urge to stand up for the deaf client, to take their side, to move from neutrality into allegiance with the deaf client against the doctor, but they know they are not supposed to do that.
- One interpreter reported about a deaf client who was so happy about his positive medical results that he started to talk to the interpreter about this in the local deaf club with a lot of other deaf people being part of the conversation. The interpreter did not really know how to handle this since she felt it could be regarded by the other deaf people present as a breach of confidentiality from her part and as such as a grave professional mistake.
- Another interpreter reported on the fact that she witnessed the deaf client lying: at a medical exam where it had to be determined how much financial benefit the deaf client would get the deaf client insisted that he couldn't speak while the interpreter knew that he could speak quite understandably. The interpreter felt that she couldn't say anything about this to the doctor examining the deaf patient, but she did feel very uncomfortable.
- One step further in this process is when the interpreter actually actively gets involved in the lie. One interpreter talked about a work-related medical exam where the deaf client claimed that he couldn't drive a car stating that the interpreter had driven him to the doctor's surgery (which was not the case). The interpreter felt she couldn't say anything about this to either the deaf client or the doctor, but did decide afterwards to never interpret for this deaf client again. However, that did not really resolve the issue and she still had not come to terms with the whole episode.

4. Conclusions

This paper reports on a first study revealing some of the problems in Flanders in interpreted health care situations. Clearly, more in-depth investigation remains absolutely necessary. Flemish Sign Language interpreters with experience in health care settings reported not only on some basic legal, financial and practical issues, but also on more challenging relational issues, the role of the interpreter from different perspectives and a number of ethical dilemmas. It has become clear from their experiences that training on these issues in health care settings is called for as most interpreters do not know how to deal with the issues discussed in this paper. Moreover many interpreters feel the need to talk about these dilemmas with other people but at the moment there

is hardly a framework for that in Flanders. Therefore some system of mentoring and monitoring seems to be called for. Furthermore, there is an absolute need for deaf clients to be informed and trained on how to use an interpreter in general, but certainly also in health care settings. Finally, it is necessary to devise ways in which health care providers can be informed on the role of the interpreter in health care settings. This will not only be beneficial to the communication between all partners, but also to the interpreters themselves and to all clients, deaf or hearing.

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